

Traumatic Death in the United States Military:

Initiating the Dialogue on War-Related Loss

Jill Harrington-LaMorie, MSW, LCSW, ACSW

Meghan McDevitt-Murphy, PhD

Citation: Harrington-LaMorie, J. & McDevitt-Murphy, M. (In Press). *Traumatic Death in the United States Military: Initiating the Dialgoue on War-Related Loss.* In R.A. Neimeyer, H. Winokuer, D. Harris & G. Thornton (Eds.), Grief and Bereavement in Contemporary Society: Bridging Research and Practice. New York, NY: Routledge.

For over two centuries young men and women have served in the United States (U.S.) military in defense, support and protection of its Constitution from enemies, both foreign and domestic. In it's lifetime, the U.S. has participated in twelve wars resulting in approximately 1.1 million accountable death casualties (CRS Report RL32492, 2010). However, the toll of death casualties does not end at the reportable number of the deceased, it is magnified exponentially by its impact to survivors affected by each individual loss.

American society has been forged on the loss of its youth in defense of the nation. Yet, how does this society accord for the loss of its youth in the care and treatment of those left behind in its wake? There exists a cavernous gap in the research literature on those impacted by the death of a loved one, friend or comrade in the U.S. Armed Services, as there are few studies on military-related death loss. With approximately 5,400 death casualties associated with the wars in Iraq and Afghanistan, the study of the impact of war-related death should emerge as a healthcare priority to provide informed-care to this population of traumatic death survivors.

Death in the U.S. Military

In peacetime and at war, the U.S. military suffers death casualties. There are many occupational hazards associated with serving in the military that can lead to deadly physical and psychological injuries. In 2009, there were 2.4 million Americans serving in the U.S. Armed Forces (United States Department of Labor, 2010) and in the past ten years there have been an average of 1,500 active duty military deaths (DoD, 2010).

Most deaths during active duty are sudden, traumatic and often violent in nature and involve the death of an adolescent or young adult. Classified circumstances of death include: accidents, hostile action, homicide, illness, pending, self-inflicted, terrorist attack and

undetermined. In the past ten years, accidents and hostile deaths have been the leading causes of death followed by self-inflicted deaths and illness (DoD, 2010).

Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF)

The Department of Defense (DoD) classifies war-related deaths into two different casualty types: non-hostile (e.g., non-hostile accidents, homicide, suicide, illness) and hostile (e.g., enemy gunfire, Improvised Explosive Device (I.E.D.), torture, sniper fire, rocket propelled grenades, suicide bombers, air losses). I.E.D.s have been responsible for almost half the death casualties of coalition forces in Iraq and currently two-thirds in Afghanistan. Multiple service members are also killed together in mass casualties through incidences such as suicide bomber attacks, air crashes and ambushes.

Each branch of the U.S. Armed Services has incurred death casualties associated with OEF and OIF, however the Army and the Marine Corps have endured the brunt of the battle. Current data provided by the DoD show that casualty deaths connected with OEF (1,142) and OIF (4,264) total 5,406 (DoD, 2010).

War and Death: The Consequences to Survivors

Death is an inherent part of war. The inevitability of the death of military service members generally does little to mitigate the overwhelming burden of grief that may face survivors following this catastrophic type of traumatic loss. For every military casualty, the loss ripples through multiple social networks, including comrades-in-arms, military leadership and personnel, surviving immediate and extended family members, friends “back home” as well as American society more broadly. To each of the affected persons, different aspects of the death likely resonate, however, there is a high likelihood for fellow service members and families who

struggle in the aftermath of these violent deaths to be exposed to the biopsychosocial impacts of both grief and trauma.

Survivors: OIF/OEF

Women and men service members have died in casualties associated with the wars in Iraq and Afghanistan. The majority of deaths have been of young, enlisted men, between the ages of 18-30 (DoD, 2010). Many are survived by a young family, extended family and friends.

Military deaths have a broad effect. Recognized primary grievers, usually include spouses, children and parents. The acute influence of grief upon fellow service members is typically quickly addressed by a unit memorial service and the implicit message for the soldier is that their grieving process is at an expected end, although the resonated feelings preside. The mission must continue and service members go right back to duty. The study of the effects of traumatic death loss (acute and long-term), interventional strategies and risk/resiliency in both these populations is immensely under-recognized.

The military formally focuses its resources and support on the Primary Next of Kin (PNOK) and Secondary Next of Kin (SNOK) listed by the service member on their personnel paperwork, most commonly spouses, parents, children and sometimes siblings. However, survivors may include: ex-spouses, fiancés, grandparents, cousins, aunt/uncle, friends, significant relationships, lovers and same-sex partners. The grief and pain of these survivors is often unrecognized, hidden, stigmatized or not acknowledged by society which can lend itself to a more complicated and disenfranchised grief process.

War, Death and Comrades-in-Arms: What We Know

For fellow service members who may have witnessed the death or learned of it soon after, the trauma of the event itself may reverberate in the form of distressing images or nightmares.

Negative emotional responses to combat have been acknowledged for some time (e.g., having been referred to as "shell shock" or "Combat neuroses" following previous wars), prior to the formal recognition and codification of posttraumatic stress disorder (PTSD) in the psychiatric nosology in the third edition of the Diagnostic and Statistical Manual of Mental Disorders, (DSM-III; APA, 1980). Since the formal recognition of PTSD as a response to combat and other traumatic events, research on the predictors, correlates and effects of this disorder has proliferated. PTSD has been linked to high rates of co-occurring disorders, including other anxiety disorders, mood disorders, and substance abuse as the most commonly co-occurring conditions and much of this research has been conducted with veterans (e.g., Kulka, et al., 1990). Despite the attention to the diverse effects of trauma among war veterans, the related subject of grief (particularly complicated grief) has received little attention.

While complicated grief has been measured only infrequently in this population, some evidence about the impact of traumatic death loss in this population may be gathered from the extant literature. For example, in an analysis of a large database of Vietnam veterans, Papa, Neria, & Litz (2008) found that, while more than three quarters of the sample had known an American soldier who was killed, just over half reported the death of a close friend in combat and these veterans reported higher levels of symptoms suggestive of complicated grief and PTSD. Another study investigated experiences of war-related bereavement symptoms of PTSD, depression, and grief in a sample of Vietnam veterans who were enrolled in inpatient therapy for PTSD (Pivar & Field, 2004). That study reported that grief-related symptoms were distinct from PTSD and depression in this population. Moreover, the data suggested that grief symptoms were more strongly associated with attachment to the military unit, closeness with military buddies, and number of losses experienced, as compared to symptoms of PTSD and depression. These

findings highlight the importance of assessing a range of clinical syndromes in combat veterans because some aspects of combat may result in symptoms of complicated grief, rather than or in addition to PTSD.

Although most of the research on the psychological sequelae of combat has had a primary focus on PTSD, it is clear that returning service members may also experience symptoms of other anxiety and mood disorders, as well as substance abuse (Hoge et al., 2004). Traumatic brain injuries have also been diagnosed frequently among veterans of the current wars in Iraq and Afghanistan (Vasterling, Verfaelle, & Sullivan; 2009). It is difficult to estimate the rate of complicated grief among veterans who may present for clinical services given the paucity of data bearing on this issue. But, the relatively high rate of psychological distress among returning OEF/OIF service personnel, particularly among those presenting for medical care at VA medical centers, and the high rate of comorbidity of psychological disorders in the wake of trauma, it is likely that CG may be present alongside other disorders that are more readily acknowledged by VAMC providers. Thus it is advisable that clinicians screen for distress related to death losses sustained in war, which may take the form of CG as treatments targeted at PTSD symptoms may not be sufficient.

The assessment and treatment of complicated grief may be addressed within the Case Conceptualization Model (CCM) proposed by Meichenbaum (2009). Using the CCM, Meichenbaum advocates taking a detailed history that includes assessment of pre-deployment factors (e.g., developmental trauma, education level), military history (e.g., number and length of deployments, nature of any injuries sustained, deaths of battle buddies, perceptions of military leadership, experiences as a prisoner of war), postdeployment experiences (e.g., time since deployment, adjustment difficulties across domains, medical history since returning from

combat), as well as the specific reasons for referral for psychological services. The CCM then guides the clinician through the assessment of presenting problems and common symptoms among returning service members including PTSD symptoms, cognitive problems, relationship difficulties. Also addressed in the model are contextual factors such as current strengths and barriers, as well as past experiences with treatment. Meichenbaum's CCM model provides a comprehensive approach to understanding a veteran's problems and to developing a treatment plan. Although complicated grief was not specifically addressed in Meichenbaum's (2009) description of this approach, it would be a relevant clinical syndrome to include in this population.

Wartime Death and Bereavement in Families: What We Know

What we know about the impacts of active duty military death and wartime bereavement in surviving families comes from studies conducted in Israel (Rubin, Malkinson & Witztum, 1999). Borne in the aftermath of the holocaust, Israel's 62 years of independence have been marked by conflict with neighboring Arab and Palestinian-Arabs states. The impact of military loss has been a principal area of bereavement research in Israel, particularly since the 1973 Yom Kippur War, which lasted 20 days and resulted in the death casualties of approximately 2,600 young adult Israeli military servicemen, wounding just over 7,200.

In a pioneer anthropological work, Palgi (1973) observed the grief and bereavement reactions of parents whose sons died in military service during the Yom Kippur War and noticed discernable responses of bereaved fathers, who seemed to be experiencing a deep sense of loss, accompanied by intense feelings of deprivation. Theses fathers seemed to age prematurely. Subsequent research on parents bereaved by military loss suggested that social withdrawal and isolation was a common consequence. Purisman and Maoz (1977) studied parents who had an

adult son killed during the War of Attrition (1969-70). Their study showed higher levels of depression and somatic complaints and poor self-concept among bereaved Israeli parents. Gay (1982) measured the self-concept of parents who lost their adult sons in the 1973 Yom Kippur War. She compared grief and adjustment scores of bereaved Israeli parents with the scores of non-bereaved Israeli adults in general society. Her findings suggested that bereaved parents ranked poorly in measures of self-concept and had higher incidences of somatic complaints and depression.

Rubin (1990) investigated Israeli parents who had lost an adult son in a war, with time since loss at an average of 9 years compared to parents who had lost a 1 year old child to illness around the same time. He discovered that parents who had adult sons who had died in war demonstrated higher levels of current grief as well as higher levels of recalled grief than parents who had suffered the death of an infant-child to illness. His research brought into question how the circumstances of death, age of the deceased and age of the bereaved parent may predispose parents to potentially more intensified grief reactions as well as complicated and enduring bereavement. As a follow-on to his findings, Rubin's studied 102 Israeli parents who had suffered the death of their sons to war in the past 4-13 years. In this second study, Rubin (1992) found that bereaved parents of fallen wartime sons showed higher levels of grief and anxiety than did the control group of 73 non-bereaved Israeli adults. This study proposed that despite the length of time since the death loss, there may be a more long-lasting impact of wartime death to parents whose grief is less inclined to subside over time.

Florian (1989-1990) aimed to investigate the perception of the meaning and purpose of life in 52 bereaved couple-parents whose sons died during active duty military service 2 years to 11years post loss. Florian compared scores on both measures to a control group of 50 non-

bereaved couple-parents. The findings of the study indicated that the bereaved parents experienced less meaning and purpose in life compared with non-bereaved parents as well as suffered poorer health and mental problems over time. This research began to identify bereaved parents as group "at-risk" for a longer, intensified and more prolonged bereavement with a predisposition for developing impairments to their physical and mental health. Based on these findings, Florian (1989-1990) suggested that in order to promote well-being of bereaved parents and improve their quality of life, mental health practitioners should seek using therapeutic interventions to help the individual regain meaning in life; encourage bereaved parents to participate in peer support self-help groups; and follow-up with bereaved parents to check on both their health and mental health status in an attempt to prevent pathological conditions.

The legacy of this loss seems to persist into late life. Malkinson and Bar-Tur (1999) reported on a focus group study of 29 bereaved older-adult parents, ages 60 to 87 years, whose sons were killed in Israeli military service 11 to 33 years prior. The most predominant theme which emerged from parents was that "grief is a private, isolating inner process" (Malkinson and Bar-Tur, 1999, p.425). They also observed that the grief of these parents continued along their lifespan, seemingly unaffected by other developmental processes or life events, and that their inner attachment to the deceased child had not been relinquished.

These studies have begun to elucidate the bereavement and the impact of sudden, often violent deaths of young adult children serving in the military upon parents. The results of their findings begin to raise the needed questions regarding the impact of war on the bereaved, however, there are limitations to their findings and limited generalizability across cultures and nations.

Each war or conflict is a unique historical event, influenced by factors such as time, era, economics, technology and culture. Surprisingly little research has explored the experience of the bereavement experiences among surviving families of service members who die in U.S. active duty military. Anecdotal reports are available in the popular press. In spite of this, the U.S. can begin to draw associations from the findings of this primary research to begin to build upon vitally needed studies in which we know very little about a population at risk for the exposure to trauma and grief.

Grief and Bereavement

Death is a universal, natural part of the human experience. Grief and bereavement following loss through death is normal, highly individualized human process (Worden, 2009). The death of a loved one, friend, co-worker, or attached relationship is considered to be one of life's most distressing events. The majority of individuals accommodate to death loss in their lives and find a way of adaptive, resilient healing (Neimeyer & Currier, 2009). However, research suggests that 10 to 20% of bereaved persons suffer from complications which can prolong acute grief reactions, impair mental and physical health; as well as prohibit an adaptive course of healing (Shear et. al, 2005).

Research has identified factors that influence the extent, intensity and manner in which individuals grieve (Worden, 2009). These factors include: relationship to the deceased; nature of the attachment; circumstances of death; history of coping with prior loss; personality; social variables and coexisting stressors.

Sudden and violent deaths predispose survivors to the collective influences of both trauma and grief. The literature suggests that those affected by sudden, violent deaths, caused by accidents, suicide, homicide, acts of terrorism and war are highly exposed to these dual

influences and are at greater risk for the potential of developing complicated grief (Doka, 1996). There is mixed opinion in the field as to when a clinician should assess for prolonged, complicated grief and this question is yet to be answered. Six months to after the first anniversary of the death have been proposed (Prigerson, et. al., 2009; Worden, 2009). However, it is highly important for the clinician to monitor and assess traumatic death loss survivors for potentially serious complications, such as suicidal ideation and intent, substance abuse, engagement in high-risk and self-destructive behaviors, symptoms of major depression and PTSD, as well as failure to thrive. These signs and symptoms should be addressed immediately as they can be life-threatening to the survivor.

Military deaths and those affected involve mediating factors which may predispose survivors to complicated grief. Clinicians and future research should explore that given these mediating factors the likelihood that survivors of a military death may experience a more complex and complicated grief process.

Complicating Factors in Wartime Deaths

There are complexities to wartime deaths unlike those seen in the civilian world (Carroll, 2001), which may compound the loss and contribute to a more distressing grief process for survivors. Wartime deaths can involve a long period of separation from the service member before the death occurs, due to trainings and deployment. In addition, other factors which may compound wartime losses include: the sudden, traumatic and violent nature of the death; dignified transfer of remains; circumstances surrounding the death; death notification; geography of the death; age of the decedent; age of the survivor/s; condition and existence of bodily remains; military rites and rituals; death investigations; the service member's commitment to

his/her duty; the survivor's viewpoint of war and military service; dealing with military and government bureaucracy; and media involvement.

Survivors are also immediately confronted with making complex decisions in the face of traumatic loss. The PNOK must navigate through a substantial amount of decisions involving voluminous paperwork associated with disposition of the remains of the service member, personal effects, insurance, entitlements and benefits. These tasks often involve interfacing with multiple macro, highly bureaucratic systems of the DoD and DVA.

Surviving U.S. Military Families

Just as the definition of survivor is broad, so too is the definition of what constitutes a military family. In this section, we describe some considerations for working with children, spouses, parents and siblings whose service members died as a consequence of current U.S wars.

Spouses

The death of a spouse in active duty U.S. military service confronts the surviving spouse with a series of compounding, multiple losses associated with their death. After the loss through death, spouses often feel the loss of a identity as a "military spouse", a way of life "military family", loss of housing (if on base/post), loss of friends through the unit/command and a loss of feeling connected to the greater military community. Members of the U.S. military and their dependent families live and function in the culture of the military which has own customs, laws, hierarchal structure, bureaucratic systems, health system, educational systems, codes of conduct, rituals, housing. For spouses, many were afforded little opportunity to develop their own careers, hobbies and support networks outside of the military due to frequent moves and the demands of the military occupation on the family. This adds to the emphasis of the idea of having to find a new identity. For many surviving spouses of regular, active duty personnel, the

death of their spouse service member is an involuntary, immediate, abrupt transition from the identity of a "military" to "civilian" family and way of life.

Clinicians should be aware of a widow/widower's potential for complex and mixed feelings regarding their spouses' commitment to their duty. These feelings may be quite definitive or a mixture of both pride and anger for their willingness to put themselves in harms way, which may contribute to a sense of personal rejection.

The face of OIF/OEF surviving spouses is young. Many are in their twenties. Young adult loss presents challenges to the survivor. Inexperience with previous deaths, coping with extreme life stressors as well as a lack of a similar peer group who have endured the death of a spouse at a young age are complications faced by OIF/OEF surviving spouses.

If the couple has children, the surviving spouse is now confronted with what to tell the children, how much to tell the children, raising children affected by traumatic grief in the midst of their own trauma and grief as well the challenges posed by single parenting.

Spouses must often make immediate decisions under complex grief and trauma regarding housing/moving (where to live/relocate), benefits, schooling for children, insurance and future employment. The military system is not always easy to navigate or compassionate in assisting with the transition of care to the survivor.

Children

The loss of a parent through war may be particularly traumatic for a child. Children may exhibit symptoms of "childhood traumatic grief" (CTG), which is characterized by symptoms similar to PTSD, including intrusive imagery related to the death (children may try to imagine the details of the death, or have recollections about the notification), avoidance of reminders of the death, which may include avoiding military events or military peers. Also like PTSD,

childhood traumatic grief may be associated with increased arousal, such that the child may have difficulty sleeping or concentrating.

The most common intervention accessed by children suffering the loss of a parent in combat are peer support groups where they may work through their trauma and grief reactions with children who are experiencing similar losses and who also share the military background and culture. The Tragedy Assistance Program for Survivors (TAPS), offers peer support "Good Grief Camps" for children and adolescents grieving the loss a loved one in U.S. military service.

Parents

The death of a child, at any age, is considered to be one of life's most devastating losses whose impacts can be pervasive overtime (Worden, 2009). A factor compounding the loss for parents and exposing them to complications in their grief is when the death is sudden, untimely and violent (Keesee, Currier, Neimeyer, 2008). Strong feelings of guilt coupled with inability to protect their child can be particularly challenging for parents whose children die young and unexpectedly. Very little attention has been paid in the literature to impact of the loss of a young adult child.

Wartime deaths are untimely, sudden, often violent and involve the death an adolescent or young adult. The majority of OIF/OEF deaths have been of young, service members, whose surviving parents are often younger adults themselves. Parents may have had little experience with the military and have difficulty dealing, gaining support or understanding the military culture, rites, rituals and bureaucracies. They also may have agreed or disagreed with their child's choice to serve in the military, especially in a time of war. Surviving parents are often confounded with the experience of confusing, conflicting emotions. Combat-related, wartime deaths present unique challenges to surviving parents. Society may assume these deaths should

be "anticipated" by the family because of their child's given line of work (Spungen, 1998) and may not be understanding of their grief.

Paradoxically, due to the highly publicized nature of the death, parents may find themselves in the role of "professional grievers" who live with the chronic spotlight of their child's death at many public services, memorial events/holidays/plaque unveilings and ceremonies. The parent's viewpoint of whether this is comforting or distressing is essential. The public label of "hero" may add to a sense of emotional confusion for parents, who may feel pride in their child's service and sacrifice, yet anger at the fact that they died.

Parents whose children die as a result of war and are not afforded what they feel is due recognition by the military or government may need further support by clinicians to help them process these feelings. Parents may not understand, and are often surprised at their own needs and responses after a child dies. Intensified feelings of guilt, anger and blame are frequently present. Anger and blame may be a reaction of bereaved parents, real or perceived. Parents may displace these feelings on the military and personnel, surviving children, other family members, and marital partners/intimate others.

Reaching out to similar others, who understand this type of loss can be a helpful and nurturing process for bereaved parents. Peer-support, self help groups have been found to be effective, in aiding parents in maintaining more positive memories of their deceased child (Klass, 1988).

Siblings

Bereaved siblings are often an unrecognized and disenfranchised group of survivors, who cope to survive in the shadow of their service member sibling's death. Even though bereaved siblings experience profound loss, they are often overlooked in their grief (Godfrey, 2006).

Society often does not recognize siblings as primary grievers, nor acknowledge the death of an adult sibling as a significant loss (Godfrey, 2006).

This too can also hold true siblings survivors of wartime deaths. Since the military focuses it resources and supports on the PNOK and SNOK, who are typically spouses and parents, siblings who are not these designees, may feel further disenfranchised in their grief from both the military and society at large. Social and emotional supports for siblings who have lost a young adult brother or sister are limited.

As with all mediating factors, how the sibling died; the nature of the sibling relationship and the dynamics of the family are also important, influencing factors in working with siblings. The death of a sibling during wartime can add another level of challenges to surviving siblings. If the death is deemed heroic, the sibling must contend with the influence this has on their role and status in the family. The "hero child" who dies young may eclipse the attachment, roles and status of other children in the family. Siblings may have difficulty processing their own feelings about their sibling's involvement and service in the war. If the death is stigmatized, this can further compound grief for siblings.

Suggested Interventions and Need for Future Research

There is very little evidence to inform our care of surviving veterans, families and service members affected the traumatic, war-related death of a friend, comrade or loved one serving in the U.S. Armed Forces. The dual exposure of both grief and trauma to these survivors leave them at risk for the development of complicated grief and PTSD. The need for study of grief in the context of traumatic military death loss is critical for this vastly neglected population of traumatic loss survivors.

If a survivor is a parent, spouse or child of a U.S. Armed service member, reservist or national Guardsman who die in the line of duty, they are eligible for bereavement counseling through the Department of Veteran's Affairs Vet Center (www.vetcenter.va.gov). Referrals for therapist and counselors who specialize in working with traumatic loss survivors can be obtained through the Association for Death Education and Counseling (www.adec.org) as well as the International Society for Traumatic Stress Studies (www.istss.org).

Finally, the power of peer support is an under-utilized but highly recognized area of healing and support to bereaved survivors. The validation and support of similar others who can bridge trusts of unique understanding is often a powerful, long-term healing component for most survivors who struggle to make meaning of the death in their lives and live in a new assumptive world. The peer connection and cultural understandings of the military and veteran community are strong. These related connections, as well as identification with a survivor-community who have suffered the loss of a U.S. military service member during wartime, may be vastly beneficial for survivors. Groups, such as the Tragedy Assistance Program for Survivors (www.taps.org), which was founded in 1994 by a military widow, provide peer based emotional support programs, for adults and children, to such survivors and are a considerable resource of care for the short and long term bereavement needs of survivors of a military death regardless of the circumstance of the death and relationship to the deceased.

References

American Psychiatric Association (1980). *Diagnostic and statistical manual of mental disorders (3rd edition)*. Washington, DC: Author.

Carroll, B. (2001). How the military family copes with a death. In O.D. Weeks & C. Johnson (Eds.), *When all the friends have gone: A guide for aftercare providers.* (pp.173-183). Amityville, NY: Baywood Publishing Company.

Cohen, J. A., Goodman, R. F., Campbell, C., Carroll, B. L., & Campagna, H. (2009). Military children: The sometimes orphans of war. In Freeman, Moore, & Freeman (Eds.) *Living and Surviving in Harm's Way* (pp. 395-416). New York: Routledge.

Congressional Research Service Report RL32492. (2010). *American War and Military Operations Casualties: Lists and Statistic.* Retrieved on July 27, 2010, from http://www.fas.org/sgp/crs/natsec/RL32492.pdf

Currier, J. M., Holland, J. M., Coleman, R. A., & Neimeyer, R. A. (2007). Bereavement following violent death: An assault on life and meaning. In R. Stevenson & G. Cox (Eds.), *Perspectives on violence and violent death* (pp. 175-200). Amityville, NY: Baywood.

Doka, K. (Ed.) (1996). *Living with grief after sudden loss: suicide, homicide, accident, heart attack, stroke.* New York, NY: Routledge (Taylor & Francis Group).

Florian, V. (1989-90). Meaning and purpose in life of bereaved parents whose son fell during active military service. *Omega Journal of Death and Dying, 20,* 91-102.

Gay, M. (1982). The adjustment of parents of wartime bereavement. In N.A. Milgram (Ed.), *Stress and Anxiety*, Vol. 8., New York: Hemisphere, 1982.

Godfrey, R. (2006). Losing a sibling in adulthood. *The Forum: Association of Death Education and Counseling, 32*(1), 6-7.

Hoge, C. W., Castro, C. A., Messer, S. C., McGurk, D., Cotting, D. I., & Koffman, R., L. (2004). Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *New England Journal of Medicine, 351*, 13-22.

Keesee., N.J., Currier, J.M., Neimeyer, R.A. (2008). Predictors of grief following the death of one's child: the contribution of finding meaning. *Journal of Clinical Psychology, 64* (10), 1145-1163.

Klass, D. (1988). *Parental grief: Solace and resolution.* New York: Springer Publishing.

Kulka, R. A., Schlenger, W. E., Fairbank, J. A., Hough, R. L., Jordan, B. K., Marmar, C. R., & Weiss, D. S. (1990). Trauma and the Vietnam war generation. New York: Brunner/Mazel.

Malkinson, R. (1987). Helping and being helped: The support paradox. *Death Studies, 11,* 205-219.

Malkinson, R. & Bar-Tur, L. (1999). The aging of grief in Israel: A perspective of bereaved parents. *Death Studies, 23,* 413-431.

Meichenbaum, D. (2009). Core psychotherapeutic tasks with returning soldiers: A case conceptualization approach. In Freeman, Moore, & Freeman (Eds.) *Living and Surviving in Harm's Way* (pp. 193-210). New York: Routledge.

Neimeyer, R. & Currier, J.M. (2009). Grief therapy: Evidence of efficacy and emerging directions. *Current Directions in Psychological Science*, *18* (6), 352-356.

Palgi, P. (1973). The socio-cultural expressions and implications of death, mourning, and bereavement arising out of the war situation in Israel. *The Israel Annals of Psychiatry and Related Disciplines, 11* (4), 301-29.

Papa, A., Neria, Y., & Litz, B. (2008). Traumatic bereavement in war veterans. *Psychiatric Annals, 38*, 686-691.

Pivar, I. L., & Field, N. P. (2004). Unresolved grief in combat veterans with PTSD. *Journal of Anxiety Disorders, 18,* 745-755.

Prigerson, H.G., Horowitz, M.J., Jacobs, S.C., Parkes, C.M., Aslan, M., Goodkin, K., Raphael, B., Marwit, S.J., Wortman, C., Neimeyer, R.A., Bonanno, G., Block, S.D., Kissane, D., Boelen, P., Maercker, A., Litz, B.T., Johnson, J.G., First, M.B., Maciejewski, P.K. (2009). Prolonged grief disorder: Psychometric validation of criteria proposed for DSM-V and ICD-11. *PLoS Medicine, 6* (8): e1000121, 1-12.

Purisman, R. & Maoz, B. (1977). Adjustment and war bereavement- some consideration. *British Journal of Medical Psychology, 50*, 1-9.

Rubin, S., (1990). Death of a future: An outcome study of bereaved parents in Israel. *Omega, 20* (4), 323-339.

Rubin, S., (1992). Adult child loss and the Two-track Model of Bereavement. *Omega, 24* (3), 183-202.

Rubin, S., Malkinson, R., & Witztum, E. (1999). The pervasive impact of war-related loss and bereavement in Israel. *International Journal of Group Tensions, 28* (1/2*),* 139-151.

Shear, K., Frank, E., Houck, P.R., & Reynolds, C.F. (2005). Treatment of complicated grief: A randomized controlled trial. *Journal of the American Medical Association, 293* (21), 2601-2608.

Spungen, D. (1998). *Homicide: The hidden victims.* Thousand Oaks, CA: SAGE Publications, Inc.

U.S. Department of Defense. (2010). *Procurement reports and data files.* Retrieved on July 27, 2010, from http://siadapp.dmdc.osd.mil/personnel/CASUALTY/Death_Rates.pdf

U.S. Department of Labor. (2010). *Occupational Outlook Handbook.* Retrieved on July 27, 2010, from http://www.bls.gov/oco/ocos249.htm

Vasterling, J. J., Verfaellie, M., & Sullivan, K. D. (2009). Mild traumatic brain injury and posttraumatic stress disorder in returning veterans: Perspectives from cognitive neuroscience. *Clinical Psychology Review, 29*, 674-684.

Worden, J.W. (2009). *Grief counseling and grief therapy: A handbook for the mental health practitioner (4th edition).* New York, NY: Springer Publishing Co., LLC.